

**WISCONSIN CHRONIC DISEASE PROGRAM (WCDP)  
HIPAA PRIVACY AUTHORIZATION FOR USE OR DISCLOSURE**

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require DHFS, as a covered entity, to implement processes that give patients certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

**INSTRUCTIONS:** Mail this completed form to the following address:

WCDP  
Participant Services  
PO Box 6410  
Madison WI 53716

You are entitled to a copy of this authorization after you sign it.

**SECTION I — RECIPIENT INFORMATION**

Name — Last, First, Middle Initial

WCDP Identification Number

Address — Street, City, State, ZIP Code

Telephone Number

(       )

**SECTION II — THE USE AND / OR DISCLOSURE BEING AUTHORIZED**

**Purpose of the use or disclosure:** Describe the purpose of the requested use or disclosure.

**Health Information to be used or disclosed:** Please specifically describe the health information records and the dates of the records you are authorizing be used and/or disclosed.

**Person or Organization I Authorize to Disclose Health Information:** Name or specifically identify the persons or organizations, including the Wisconsin Chronic Disease Program (WCDP), who you are authorizing to disclose the health information described above. *Please include the address and telephone number for persons and/or organizations other than the WCDP.*

Name

Telephone Number

(       )

Address

Name

Telephone Number

(       )

Address

*Continued*

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**SECTION II — THE USE AND / OR DISCLOSURE BEING AUTHORIZED (Continued)**

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**Person or Organization to Receive and Use:** Name or specifically describe the persons or organizations, including addresses and telephone numbers, to whom you are authorizing the WCDP to disclose to or let use the health information as previously described:

Name	Telephone Number (       )
Address	

Name	Telephone Number (       )
Address	

I understand that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. State health record privacy regulations will still apply to my health information.

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**SECTION III — EXPIRATION AND REVOCATION**

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Expiration: This authorization will expire as follows (complete one):

☐ On \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YYYY), or

☐ On occurrence of the following event (which must relate to the recipient or to the purpose of the use or disclosure being authorized):

**Right to Revoke:** I understand that I may revoke all or part of this authorization at any time by giving written notice of my revocation to the Privacy Office information listed below. I understand that revocation of this authorization will *not* affect any action taken in reliance on this authorization before receiving my written notice of revocation.

WCDP  
Participant Services  
PO Box 6410  
Madison WI 53716

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**SECTION IV — SIGNATURES**

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I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the WCDP. I understand that, by signing this form, I am confirming my authorization that the WCDP may use or disclose to the persons or organizations named in this form the health information described in this form. I also understand that the WCDP will not condition payment, enrollment, or eligibility for benefits in the WCDP on the signing of this authorization.

<b>SIGNATURE — Recipient</b>	Date Signed
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**If this authorization is signed by a personal representative on behalf of the recipient, provide a copy of the documentation to support the representation and complete the following:**

Name — Personal Representative	Relationship to Recipient
<b>SIGNATURE — Personal Representative</b>	Date Signed

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